Massachusetts Mental Health Parity Laws and the Federal Mental Health Parity and Addiction Equity Act (MHPAEA)

This notice is sent to give you information about your benefits for mental health and substance use disorder services. Under both Massachusetts laws and federal laws, benefits for mental health services and substance use disorder services must be comparable to benefits for medical/surgical services. This means that copays, coinsurance and deductibles, for mental health and substance use disorder services must be at the same level as those for medical/surgical services. Also, our review and authorization of mental health or substance use disorder services must be handled in a way that is comparable to the review and authorization of medical/surgical services.

If we make a decision to deny or reduce authorization of a service, we will send you a letter explaining the reason for the denial or reduction. We will send you or your provider a copy of the criteria used to make this decision, at your request.

If you think that we is are not handling your benefits for mental health and substance use disorder services in the same way as for medical/surgical services, you may file a complaint with the Division of Insurance (DOI) Consumer Services Section.

You may file a written complaint using the DOI's Insurance Complaint Form. You may request the form by phone or by mail or find it on the DOI's webpage at:

http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html

You may also submit a complaint by phone by calling 877-563-4467 or 617-521-7794.
If you submit a complaint by phone, you must follow up in writing and include your name and address, the nature of your complaint and your signature authorizing the release of any information.

Filing a written complaint with the DOI is not the same as filing an appeal under your plan. You must also file an appeal with us in order to have a denial or reduction in coverage of a service reviewed. This may be necessary to protect your right to continued coverage of treatment while you wait for an appeal decision. Follow the appeal procedures outlined in your plan for more information about filing an appeal.

Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Walmart

Group policy number: GP-895530-AR
Group control number: CN-486824

Amendment effective date: January 1, 2021

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Massachusetts. The benefits below will apply instead of those in your booklet-certificate.

Physician Profiling

Physician profiling information is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

Interpreter and Translation Services

You may contact Member Services at the toll-free telephone number listed on your I.D. card to receive information on interpreter and translation services related to administrative procedures. A TDD# for the hearing impaired is also available.

French
Services d'interprétation et de traduction
Vous pouvez contacter les services aux membres au numéro de téléphone sans frais indiqué sur votre carte d'identification pour recevoir de l'information sur les services d'interprétation et de traduction se rapportant aux procédures administratives. Les professionnels du service à la clientèle Aetna ont accès à des services de traduction par le biais des services linguistiques téléphoniques de AT&T. Un numéro de téléphone ATME est aussi disponible pour les malentendants.

Greek
Υπηρεσιες Μεταφρασεως
Για να λαβετε πληροφοριες οσον αφορα των υπηρεσιων μας μεταφρασεως σχετικα με την διαδικασια διοικητικη, μπορειτε να ερχοσαστε σε επαφη με την Υπηρεσια για τα Μελη στον αριθμο (χρωις διοδια) που βρισκεται επανω στην εξακριβωση σας ταυτοτητας. Οι επαγγελματικοι υπαλληλοι (του τμηματος της Αετνα το οποιο ανασχολειται με τους πελατες) μπορουν να χρησιμοποιουν την μεταφραστικη υπηρεσια της εταιρειας AT&T.

Italian

Servizi di traduzione e di interpretariato

Per ottenere informazioni sui servizi di traduzione e interpretariato connessi a procedure amministrative, potete rivolgervi al Servizio Membri chiamando il numero di linea verde indicato sulla vostra carta di ID. I professionisti del servizio clientela della Aetna hanno accesso ai servizio di traduzione della linea linguistica della AT&T. È anche disponibile un No TDD per i deboli di udito.

Portuguese

Serviços de Intérprete e de Tradução

Você poderá entrar em contato com os Serviços dos Associados ao telefone livre de tarifa indicado no seu cartão de identificação para obter informações sobre serviços de intérprete e de tradução com relação aos procedimentos administrativos. Os profissionais dos serviços aos clientes têm acesso aos serviços de tradução através da linha de idiomas da AT&T. Existe também uma linha TDD para quem tem dilficuldades com a audição.

Russian

Услуги по устному и письменному переводу

Чтобы получить информацию о предоставляемых услугах устного и письменного перевода, вы можете обращаться в отдел обслуживания членов программы по бесплатному номеру телефона, указанному на вашей членской карточке. Сотрудники Aetna по обслуживанию клиентов имеют доступ к переводческим услугами по языковой линии AT&T. Имеется также устройство связи для лиц с дефектами слуха (TDD).

Spanish

Servicio de Intérprete y Traducción

Usted puede ponerse en contacto con Servicios a Miembros, al número de teléfono gratis que aparece en su tarjeta de identificación para recibir información sobre servicios de intérprete y traducción relativo a los procedimientos administrativos. Los profesionales de servicio a clientes de Aetna tienen acceso a los servicios de traducción por medio de la linea de idiomas de AT&T. Además hay un número de TDD para las personas con impedimento de audición.

Haitian-Creole

Sèvis intèprèt ak tradiktè

Ou kapab pran kontak avèk Sèvis pou manm-yo si ou rele nimewo telefòn gratis ki sou kat I.D.-ou-a (idantifíkasyon) pou ou jwenn ransèyman sou sèvis intèprèt ak tradiktè konsènan pwosedi administratif. Pwofesyonnèl nan sèvis kliyan “Aetna” gen mwayden jwenn sèvis tradiksyon nan “AT&T language line” (sèvis lang AT&T). Yon nimewo TDD disponnib tou pou moun ki pa tande byen.

Lao

ານບໍລິການນາຍພາສາແລະການແປພາສາ

່ານສາມາດຕິດຕໍ່ພະແນກບໍລິການສະມາຊິກໄດ້ ໂດຍໃຊ້ເບີໂທບໍລິການຟຣີທີ່ປາກົດເທິງບັດປະຈຳ ົວສະມາຊິກຂອງທ່ານ ເພື່ອໄດ້ຮັບລາຍລະອຽດຕ່າງໆ ກ່ຽວກັບການບໍລິການນາຍພາສາແລະ ລິການແປພາສາທີ່ກ່ຽວຂ້ອງກັບການດຳເນີນການທາງດ້ານການບໍລິຫານ. ພະນັກງານຂອງ ແນກບໍລິການລູກຄ້າຂອງບໍລິສັດເອັດນາ (Aetna) ສາມາດຕິດຕໍ່ກັບການບໍລິການທາງດ້ານ ານແປພາສາໄດ້ ໂດຍຜ່ານສາຍແປພາສາ (Language Line) ຂອງບໍລິສັດ AT&T. ຍັງ ເບີໂທຂອງລະບົບ TDD ໄວ້ສຳຫລັບຜູ້ທີ່ໄດ້ຍິນສຽງບໍ່ຄັກໃຊ້ໃນການຕິດຕໍ່ອີກດ້ວຍ.

Cambodian

សេវាកម្មផ្នែកបកប្រែភាសា

អ្នកអាចទាក់ទងសេវាកម្មសមាជិក តាមរយៈលេខ ឥតគិតថ្លៃ ដែលចុះនៅលើកាតសំគាល់របស់ អ្នក ដើម្បីទទួលពត៌មាន អំពី សេវាកម្មផ្នែកបកប្រែភាសា ដែលទាក់ទងនឹងវិធីចាត់ចែងការ ។ អ្នកជំនាញការផ្នែកសេវាកម្មនៃអតិថិជនរបស់ Aetna **មានមធ្យោបាយរកសេវាកម្មបកប្រែ តាមរយៈខ្សែទូរស័ព្ទភាសា** AT&T **។ លេខ** TDD# **សំរាប់មនុស្សគថ្លង់ ក៏មានផងដែរ ។**

Chinese

口譯及筆譯服務

您可以通過撥打列在您會員卡上的免費電話號碼與會員服務處聯絡，以便獲取有關實施程序的口譯及筆譯服務的資訊。Aetna的專業用戶服務人員使用AT&T語言專線 (AT&T Language Line) 的翻譯服務。還有一個專門為聽力有障礙的用戶提供的TDD號碼。

Arabic

خدمات الترجمة الشفهية والكتابية

تستطيع الاتصال بدائرة خدمات الأعضاء على رقم الهاتف المجاني المدرج على بطاقة هويتا للحصول على معلومات حول خدمات الترجمة الشفهية والكتابية المتعلقة بالإجراءات الإداريا فموظفو دائرة خدمة الزبائن لدى شركة Aetna يستطيعون تلقي خدمات الترجمة عن طري خط اللغات لشركة AT&T. ويتوفر للأصماء أيضاً رقم جهاز إتصالات الأصماء (TDD).

In no event will the covered amount for In-Network charges exceed more than 20% of the covered amount for Out-of-Network charges.

Which Plan Pays First *(GR-9N 33-010 03 MA)*

When two or more **plans** pay benefits, the rules for determining the order of payment are as follows**:**

- The **primary plan** pays or provides its benefits as if the **secondary plan** or **plans** did not exist.
- A **plan** that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the **plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a **closed panel plan** to provide out-of-network benefits.
- A **plan** may consider the benefits paid or provided by another **plan** in determining its benefits only when it is secondary to that other **plan**.
- The first of the following rules that describes which **plan** pays its benefits before another **plan** is the rule to use:

1. Medical Payments Coverage and PIP Coverage in Motor Vehicle Insurance Policies.
   If a person is covered under a motor vehicle policy and incurs expenses or requires services as a result of an accident with a motor vehicle:

   A. Personal Injury Protection (PIP) is the **primary plan** for the first $2,000 of expenses. After that, **plans** will coordinate benefits in accordance with these coordination of benefits provisions.

   PIP refers to the personal injury protection coverage included in a motor vehicle liability insurance policy.

   B. MedPay means medical coverage that can be purchased in connection with a motor vehicle liability policy. MedPay will always be secondary to and in excess of any other **plan** or PIP.

2. Non-Dependent or Dependent. The **plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the **plan** that covers the person as a dependent is secondary. However, if the person is a **Medicare** beneficiary and, as a result of federal law, **Medicare** is secondary to the **plan** covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two **plans** is reversed so that the **plan** covering the person as an employee, member, subscriber or retiree is secondary and the other **plan** is primary.

3. Child Covered Under More Than One **Plan**. The order of benefits when a child is covered by more than one **plan** is:

   A. The **primary plan** is the **plan** of the parent whose birthday is earlier in the year if:

      i. The parents are married or living together whether or not married;

      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the **plan** that covered either of the parents longer is primary.

B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the **plan** of that parent has actual knowledge of those terms, that **plan** is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the **primary plan**.

- If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage , the order of benefits is:

  - The **plan** of the **custodial parent**;
  - The **plan** of the spouse of the **custodial parent**;
  - The **plan** of the non**custodial parent**; and then
  - The **plan** of the spouse of the non-**custodial parent**.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

4. Active Employee or Retired or Laid off Employee. The **plan** that covers a person as an employee who is neither laid off nor retired, or as a dependent of an active employee, is the **primary plan**. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the **secondary plan**. If the other **plan** does not have this rule, and if, as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another **plan**, the **plan** covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other **plan** does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

6. Longer or Shorter Length of Coverage. The **plan** that covered the person as an employee, member, or subscriber longer is primary.

7. If the preceding rules do not determine the **primary plan**, the allowable expenses shall be shared equally between the **plans** meeting the definition of **plan** under this provision. In addition, **This Plan** will not pay more than it would have paid had it been primary.]

(GR-9N 29-010-01)

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship, or whose parent is your child and is covered as a dependent under the plan.

When You Receive a Qualified Child Support Order *(GR-9N 29-015-01 MA)*
A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

If you fail to make an application to obtain coverage of a child, **Aetna** shall enroll such child upon application by such child's other parent, by the division of medical assistance or upon receipt of a national medical support notice from the IVD agency.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Long-term Antibiotic Therapy for Lyme Disease

Covered expenses include long-term antibiotic therapy for Lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation of the patients' symptoms, diagnostic test results or response to treatment. Further, an experimental drug shall be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration; provided, however, that a drug, including an experimental drug, shall be covered for an off-label use in the treatment of Lyme disease if the drug has been approved by the United States Food and Drug Administration.

Prosthetic Devices *(GR-9N 11-110-01 MA)*

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators;
- A durable brace that is custom made for and fitted for you;
- A scalp hair prosthesis (wig) for hair loss due to treatment of any form of cancer or leukemia;
- Therapeutic/molded shoes and shoe inserts required for the treatment of or to prevent complications of diabetes.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items or
- any item listed in the *Exclusions* section.

Gatekeeper PPO Medical Plan *(GR9N 11 80 01 MA)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Any coinsurance requirement for artificial limb devices to replace, in whole or in part, an arm or leg will not exceed 20%, unless such coinsurance applies to all covered benefits. With respect to Out of Network charges, any coinsurance will not exceed 40% of the cost unless such coinsurance applies to all covered benefits under the plan.		
Scalp Hair Prosthesis for Cancer or Leukemia Patients *(GR-9N-S10-95-01 MA)*	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Benefit per Calendar Year	$350	$350

Cleft Lip or Palate Treatment

Treatment of Cleft Lip or Palate of Dependent Children Under Age 18

Covered expenses include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Medical, dental, oral surgery and facial surgery, surgical management including pre- and post-operative care provided by oral and plastic surgeons;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;
- Preventative and restorative dentistry to ensure good health;
- Adequate dental structures for orthodontic treatment or prosthetic management therapy;
- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;
- Audiology;
- Nutrition services;
- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage.

If such services are prescribed by the treating physician or surgeon and such physician or surgeon certifies that such services are medically necessary and consequent to the treatment of the cleft lip, cleft palate or both.

Payment for dental or orthodontic treatment not related to the management of the congenital conditions of cleft lip and cleft palate will not be covered under this section.

Limitations

Unless specified above, not covered under this benefit are:

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

Hearing Aids Expense

Covered expenses include charges incurred by a covered person for the cost of one hearing aid per hearing impaired ear every 36 months upon written statement from the covered person's treating physician that the hearing aid(s) are necessary regardless of etiology.

Covered expenses also include related services prescribed by a licensed audiologist or hearing instrument specialist, including the initial hearing aid evaluation, fitting and adjustments and supplies, including ear molds.

Coverage is provided under the same terms and conditions as for any other condition.

Hearing Aids *(GR-9N-S-10-80-05 MA)*	90% per item after Calendar Year **deductible**	70% per item after Calendar Year **deductible**

Clinical Trial Expenses *(GR-9N 11-210-01 MA)*

This Plan will pay for **medically necessary** and routine patient care, **physician**, and facility charges you incur when enrolled in a qualified clinical trial study.

A "qualified clinical trial" means a patient research study that meets the following criteria:

- it must be intended to treat cancer; and
- it must be peer reviewed and approved by one of the following:
  - one of the United States Institutes of Health;
  - a center or cooperative group of the National Institutes of Health;
  - a qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
  - the Food and Drug Administration (FDA) pursuant to an investigational new drug exemption;
  - the Department of Defense;
  - the Department of Veterans Affairs; or
- with respect to a Phase II, III and IV clinical trial
  - a qualified institutional review board; and
  - it must be provided by a provider of health care which has the experience and training to provide the treatment in a capable manner; and
- with respect to Phase I clinical trials
  - it must be provided by an academic medical center or affiliated facility, and the providers conducting the trial shall have staff privileges at the academic medical center; and
  - you meet the patient selection criteria for participation in the qualified clinical trial; and
  - you must have signed, prior to participation in the qualified clinical trial, a statement of consent.
- available clinical or pre-clinical data provide a reasonable expectation that participation is likely to be beneficial to you; and
- it does not duplicate existing studies; and
- it must have a therapeutic intent and must assess the effect of the intervention.

Charges for **covered expenses** you incur for the treatment provided in the clinical trial are payable on the same basis as any disease or illness covered under this plan.

Any care provided in the clinical trial must be for services that are considered **covered expenses** under this plan. They must be consistent with all of the terms and conditions of this plan including but not limited to:

- Aetna's Clinical Guidelines and Utilization Review criteria; and
- Quality Assurance program.

Clinical trial expenses are subject to all of the terms; conditions; provisions; limitations; and exclusions of this plan including, but not limited to: precertification and referral requirements.

Not covered under this plan are:

- any drug or device that is approved by the FDA, even when the off-label use of the drug or device has not been approved by the FDA for that indication, if the drug or device is paid for by the manufacturer, distributor, or provider of the drug or device; and
- any expenses customarily paid by a government, or by a biotechnical, pharmaceutical or medical industry; and
- costs of data collection and record-keeping that would not be required but for the clinical trial; and
- any expenses for the management of research; and
- any expenses related to participation in the clinical trial; and
- services and supplies provided "free of charge" by the trial sponsor to the covered person.

Psychiatric Physician

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, drug abuse, **mental disorders**, or **serious mental illnesses**.

For Massachusetts residents, to the extent required by law, this also includes the following licensed providers:

- Psychologist;
- Independent Clinical Social Worker;
- Mental Health Counselor;
- Nurse Mental Health Clinical Specialist; and
- Marriage and Family Therapist.

Telemedicine *(GR-9N-S-11-020-01)*

Covered expenses include the application of telemedicine for covered services provided by a **physician** acting within the scope of their license as a method of delivery of medical care by which an individual shall receive medical services from a health care provider without in-person contact with the provider. Coverage is provided for only those services that are **medically necessary** and subject to the terms and conditions of the covered person's policy. Coverage for health care services under this provision will be consistent with coverage for health care services provided through an in-person consultation.

Telemedicine means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine or e-mail.

Aetna may limit coverage of telemedicine services to those health care providers in a telemedicine network approved by **Aetna**.

The deductible, copayment or coinsurance will not exceed any deductible, copayment or coinsurance applicable to an in-person consultation.

Treatment of Speech, Hearing and Language Disorders *(GR-9N 11-145-01 MA)*

The plan will pay for the diagnosis and treatment by individuals licensed as speech-language pathologists or audiologists for acute speech, hearing and language disorders, but only if the services are made for:

- Diagnostic services rendered to find out if, and to what extent, your ability to speak or hear is lost or impaired;
- Rehabilitative services rendered that are expected to restore or improve your ability to speak or hear.

The treatment of speech, hearing and language disorders benefit does ***not*** cover:

- Diagnostic or rehabilitative services rendered before you become eligible for coverage or after termination of coverage;
- Special education (including lessons in sign language) to instruct you if your ability to speak or hear is lost or impaired, to function without that ability.
- Hearing aids, hearing aid evaluation tests, and hearing aid batteries;
- Hearing exams required as a condition of employment;
- Diagnostic or rehabilitative services for treatment of speech, hearing, and language disorders:
  - that any school system, by law, must provide; or
  - as to speech therapy, to the extent such coverage is already provided for under Early Intervention Services and Home Health Care Services; or
- Any services unless they are provided in accordance with a specific treatment plan which:
  - details the treatment to be rendered and the frequency and duration of the treatment;
  - provides for ongoing services; and
  - is renewed only if such treatment is still necessary.

Early Intervention Services Expenses *(GR9N 11 020 03 MA)*

Covered expenses include early intervention services provided by early intervention specialists who are working in early intervention programs certified by the department of public health upon referral by the **Physician** for dependents from birth until thirty six (36) months of age.

Early Intervention *(GR9N 11 025 06 MA)*	No **copay, coinsurance** or **deductible** applies.	No **copay, coinsurance** or **deductible** applies.

Autism Spectrum Disorders *(GR-9N 11-171 04 MA)*

Definitions:

Applied behavior analysis: the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism services provider: a person, entity or group that provides treatment of autism spectrum disorders.

Autism spectrum disorders: any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

Board certified behavior analyst: a behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.
Diagnosis of autism spectrum disorders: medically necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has 1 of the autism spectrum disorders.

Treatment of **autism spectrum disorders**: includes the following care prescribed, provided or ordered for an individual diagnosed with 1 of the **autism spectrum disorders** by a licensed physician or a licensed psychologist who determines the care to be medically necessary: habilitative or rehabilitative care; pharmacy care; psychiatric care; psychological care; and therapeutic care.

Covered expenses include charges made by a **physician** or **behavioral health provider** for services and supplies for the following . The services and supplies must be ordered by a **physician** or a **behavioral health provider.**

Coverage includes diagnosis and medically necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has an ASD.

Treatment includes the following medically necessary care prescribed, provided or ordered for an individual diagnosed with an ASD by a licensed physician or a licensed psychologist.

- Habilitative or Rehabilitative Care: Professional, counseling and guidance services and treatment programs, including, but not limited to, applied behavioral analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual. Applied behavior analysis includes the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including in the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

- Pharmacy Care: Medications prescribed by a licensed physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the health plan for other medical conditions.

- Care from a Psychiatrist: Direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

- Psychological Care: Direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

- Therapeutic Care: Services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

- Applied behavior analysis (ABA).

Limitations:
Unless specified above, not covered under this benefit are charges for:
- Educational services for behavioral disorders are listed as not covered in the Medical Plan Exclusions and Limitations section of the Policy.

Preventive Health Care Services *(GR-9N 11-225-01 MA)*

The plan covers preventive health care services even though they are not incurred in connection with an **injury** or **illness**. They are included only for a dependent child under 6 years of age.

Preventive health care services are services provided for a routine exam of the child. Included are:

- A review and written record of the child's complete medical history;
- Taking measurements and blood pressure;
- Developmental and behavioral assessment;
- Vision and hearing screening, including a newborn hearing screening test performed before the child is discharged from the **hospital** or **birthing center**;
- Lead poisoning screening;
- Other diagnostic screening tests including:
  - One series of hereditary and metabolic tests performed at birth; and
  - Urinalysis, tuberculin test, and blood tests such as hematocrit and hemoglobin tests.
- Immunizations for infectious disease; and
- Counseling and guidance of the child and the child's parents or guardian on the results of the physical exam.

Covered expenses will only include charges for preventive health care services performed at birth and at approximately each of the following ages:

2 months
4 months
6 months
9 months
12 months
15 months
18 months
2 years
3 years
4 years
5 years

Not covered under this benefit are charges incurred for:

- Services which are covered to any extent under any other part of the plan;
- Services which are covered to any extent under any other group plan sponsored by your Employer;
- Services for diagnosis or treatment of a suspected or identified injury or illness;
- Services not performed by a **physician** or under their direct supervision;
- Medicines, drugs, appliances, equipment or supplies;
- Dental exams.

Routine Cancer Screenings *(GR-9N 11-005-01 MA)*

Covered expenses include charges incurred for routine cancer screening as follows:

- 1 baseline mammogram, for covered females age 35 but less than 40;
- 1 mammogram every 12 months for covered females age 40 and over;
- 1 Pap smear every 12 months.

Treatment of Infertility *(GR-9N 11-135 06 MA)*

Basic Infertility Expenses

Covered expenses include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses

To be an eligible covered female for benefits you must be covered under this *Booklet-Certificate* as an employee, or be a covered dependent, who is the subscriber's legal spouse or domestic partner, referred to as "your partner".

Even though not incurred for treatment of an **illness** or **injury**, **covered expenses** will include expenses incurred by an eligible covered female for **infertility** if all of the following tests are met:

- A condition that is a demonstrated cause of **infertility**, has been recognized and diagnosed as **infertility**, by a gynecologist, infertility specialist, or your **physician**, and it has been documented in your medical records.
- The procedures are done; while not confined in a hospital; or any other facility; as an inpatient.
- The **infertility** is not caused by voluntary sterilization of either one of the partners (without surgical reversal). This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this *Booklet-Certificate*.

Comprehensive Infertility Services Benefits

If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an **infertility specialist** upon **precertification** by **Aetna**, subject to all the exclusions and limitations of this *Booklet-Certificate*:

- Ovulation induction with menotropins; and
- Artificial insemination and intrauterine insemination.

Advanced Reproductive Technology (ART) Benefits

Advanced Reproductive Technology is defined as:

- In vitro fertilization (IVF-EP);
- Zygote intrafallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);
- Cryopreserved embryo transfers;
- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery

ART services are defined as:
ART services, products, and procedures that are **covered expenses** under this *Booklet-Certificate*.

Infertility Case Management is defined as a program administered by **Aetna** that consists of:

- Evaluation of medical records to determine whether **ART services** are **medically necessary**;
- Determination of whether **ART services** are covered benefits;
- Pre-authorization for ART services by an **ART Specialist** when **ART services** are **medically necessary** and are covered benefits; and
- Case management for the provision of **ART services** for an eligible covered person.

Eligibility for ART Benefits

To be eligible for **ART** benefits under this *Booklet-Certificate*, you must meet the requirements above and:

- You first exhaust the comprehensive infertility benefits. Coverage for **ART services** is available only if comprehensive **infertility** services do not result in a pregnancy in which a fetal heartbeat is detected.
- Be referred by your **physician** to the infertility case management unit;
- Be issued **precertification** for **ART services** by the infertility case management unit to an **ART specialist**.
- **ART services** are available only from the **ART specialists** for whom you have been issued a **precertification** by **Aetna's** infertility case management unit. Treatment received without pre-authorization will not be covered and you will be responsible for payment of all services..

Covered ART Benefits

The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the *Exclusions and Limitations* section of the *Booklet-Certificate*:

- IVF-EP; GIFT; ZIFT; or cryopreserved embryo transfers;
- ICSI, assisted hatching or ovum microsurgery;
- Payment for charges associated with the care of an eligible covered person under this Plan who is participating in a donor IVF-EP program, including fertilization and culture;
- Charges associated with obtaining sperm, egg and/or inseminated egg procurement and processing and bank of sperm or inseminated eggs, for **ART**, when the spouse is also covered under this Booklet-Certificate; and
- Egg and/or inseminated egg procurement and processing bank sperm inseminated eggs for **ART** to the extent such costs are not covered by the donor's insurer.

Exclusions and Limitations

Unless otherwise specified above, the following charges will not be payable as **covered expenses** under this *Booklet-Certificate*:

- **ART services** for a female attempting to become pregnant who has <u>not</u> had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the **infertility** program;
- **ART services** for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal; unless that person can document that there has been a successful reversal of a sterilization procedure and has been unable to conceive or produce conception for a period of 1 year if the female is age 35 or younger, or during a period of 6 months if the female is over the age of 35;
- Reversal of sterilization surgery;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the gestational carrier. This exclusion does not apply to sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs to the extent such costs are not covered by the donor's insurer;
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits or related to the treatment of **infertility** that are not **medically necessary**;;
- Any services or supplies provided without **precertification** from **Aetna's** infertility case management unit;

- **Infertility** and **ART** Services that do not meet the **Medical Necessity** guidelines;
- Ovulation induction and intrauterine insemination services if you are not **infertile**;
- Services and supplies obtained without **precertification** from the **infertility** case management unit;
- If you have Prescription Drug Coverage that includes oral and self-injectable infertility drugs, then oral and self-injectable infertility drugs are excluded under your medical plan.

Coverage under this benefit will terminate immediately upon termination of coverage under this *Booklet-Certificate*, subject to group continuation coverage requirements under COBRA or state continuation laws.

Important Note
Treatment received without **precertification** will not be covered. You will be responsible for full payment of the services.

Refer to the Schedule of Benefits for details about the maximums that apply to **infertility** services. The **lifetime maximums** that apply to **infertility** services apply differently than other **lifetime maximums** under this Plan.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment *(GR-9N S11-55-01 MA)*		
Basic and Comprehensive Infertility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Advanced Reproductive Technology (ART) Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Diabetic Equipment, Supplies and Education *(GR-9N 11-135 02 MA)*

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- Insulin and Insulin preparations;
- External insulin pumps;
- Syringes;
- Injection aids for the blind;
- Test strips and tablets, including blood glucose monitoring strips, ketone strips;
- Blood glucose monitors without special features unless required due to blindness;
- Lancets;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training;
- Foot care to minimize the risk of infection;
- All lab tests and urinary profiles;
- Voice synthesizers and visual magnifying aids;
- Therapeutic/molded shoes and shoe inserts;
- Insulin pump supplies;
- Insulin pens; and
- Oral medications.

Physician Visits *(GR-9N 11-020-01 MA)*

Covered expenses also include:

- Diabetic Self-Management Education: Training designed to instruct a person in self-management of diabetes. It may also include training in self care or diet. Such charges must be made by:
  - a **physician**, nurse practitioner, clinical nurse specialist; or
  - a **pharmacy** or dietician who is legally qualified by the *Commonwealth of Massachusetts* to provide diabetic management education.
- Your diabetic equipment and self-management education services benefit does *not* cover:
  - a diabetic education program whose only purpose is weight control; or which is available to the public at no cost; or
  - a general program not just for diabetics; or
  - a program made up of services not generally accepted as necessary for the management of diabetes.

Important Reminder
Certain procedures need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.

Hormone Replacement Therapy *(GR-9N 11-200-01 MA)*

The plan will pay for outpatient services and supplies related to your hormone replacement therapy for peri and post menopausal women on the same basis as any other **illness**.

Contraception Services *(GR-9N 11-005-01 MA)*

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a **physician** provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Pregnancy Related Expenses *(GR-9N 11-100-01 MA)*

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

If the mother is discharged earlier, the plan will pay for home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit be conducted by a registered nurse, **physician**, or certified nurse midwife; and provided that any subsequent home visits determined to be clinically necessary shall be provided by a licensed health care provider.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Treatment of Mental Disorders and Substance Abuse *(GR-9N 11-172 01 MA)*

Treatment of Mental Disorders *(GR-9N 11-172-06 MA)*

Covered expenses include chargers made for the treatment of **Biologically-Based Mental Disorders** and **Non-Biologically Based Mental Disorders** by **Behavioral Health Providers** under the same terms and conditions and which are no less extensive than coverage provided for any other type of health care for physical illness. This includes the same copayments, coinsurance or deductibles.

Benefits consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary and active and noncustodial treatment to take place in the least restrictive clinically appropriate setting..

In addition to the above, **covered expenses** also include charges made for:

- Rape Related Mental or Emotional Disorders - Coverage shall be provided for the diagnosis and treatment of rape related mental or emotional disorders if the **covered person** is a victim of a rape or victim of an assault with intent to commit rape under the same terms and conditions and which are no less extensive that coverage provided for any other type of health care for physical illness.

- Children and Adolescents under the age of 19 - Benefits shall be covered under the same terms and conditions and which are not less extensive than coverage provided for any other health care for physical illness, for children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care provider, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including but not limited to:

  (1) an inability to attend school as a result of such a disorder;
  (2) the need to hospitalize the child or adolescent as a result of such a disorder;
  (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

  Coverage shall be continue to be provided to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect.

- Covered expenses also include psychopharmacological services and neuropsychological assessment services.

DEFINITIONS:
BIOLOGICALLY BASED MENTAL DISORDERS
(1)schizophrenia; (2) schizoaffective disorder; (3) major depressive disorder; (4) bipolar disorder; (5) paranoia and other psychotic disorders; (6) obsessive-compulsive disorder; (7) panic disorder; (8) delirium and dementia; (9) affective disorders; 10) eating disorders; (11) post traumatic stress disorder; (12) substance abuse disorders; and (13) autism.

OUTPATIENT SERVICES
Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:

- Office Visits to a **physician (**such as a **psychiatrist)**, psychologist, social worker, or licensed professional counselor, as well as other health professionals (includes **telemedicine** consultation).
- Individual, group and family therapies for the treatment of mental disorders.
- Other outpatient **mental disorder** treatment such as:
  - Outpatient **detoxification**.
  - **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a **physician**. The facility or program does not make a **room and board** charge for the treatment.
  - Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program under the direction of a **physician**.
  - Ambulatory **detoxification** – Outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications.

- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
  - You are homebound because of **illness** or **injury**.
  - Your **physician** orders them.
  - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home.
  - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
- Mental health injectables
- Treatment of withdrawal symptoms.
- Substance use disorder injectables.
- 23 hour observation.
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing

INTERMEDIATE SERVICES

- Acute and other residential treatment
- Crisis stabilization

INPATIENT SERVICES
may be provided in

- a general hospital licensed to provide such services,
- in a facility under the direction and supervision of the department of mental health
- private mental hospitals licensed by the department of mental health, and substance abuse facilities licensed by the department of public health.

LICENSED MENTAL HEALTH PROFESSIONAL

- a licensed physician who specializes in the practice of psychiatry,
- a licensed psychologist,
- a licensed independent clinical social worker,
- a licensed mental health counselor,
- a licensed nurse mental health clinical specialist,
- a licensed alcohol and drug counselor, or
- a licensed marriage and family therapist within the lawful scope of practice for such therapist.

Substance Abuse*(GR-9N 11-172-03 MA)*

Covered expenses include charges made for the treatment of **substance abuse** by **behavioral health providers.** In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a **behavioral health provider;** and
- The program of therapy includes either:
  - A follow up program directed by a **behavioral health provider** on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or **substance abuse**.

Please refer to the *Schedule of Benefits* for any **substance abuse deductibles,** maximums, **coinsurance limits** or **maximum out-of-pocket limits** that may apply to your **substance abuse** benefits.

Inpatient Treatment

This Plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **hospital** as well as a facility under the direction and supervision of the department of mental health, in a private mental hospital, or in a substance abuse facility appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of **substance abuse**.
- "Medical complications" include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital** is covered only when the **hospital** does not have a separate treatment facility section.

Important Reminder
Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Intermediate Care Treatment

Covered Medical Expenses include, but are not limited to, Level III community-based detoxification, acute residential treatment, partial confinement treatment, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for **substance abuse** while not confined as a full-time inpatient in a **hospital**, as well as a facility under the direction and supervision of the department of mental health, or in a private mental hospital, or in a substance abuse facility. Outpatient treatment may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license.

Important Reminders:

- Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums, **coinsurance limits** or **maximum out-of-pocket limits** that may apply to your **substance abuse** benefits.

Behavioral Health Provider *(GR-9N 34-010-01 MA)*

A licensed facility, organization or **other health care** provider furnishing diagnostic and therapeutic services for treatment of alcoholism, drug abuse, **mental disorders** acting within the scope of the applicable license. This includes:

- **Hospitals**;
- Psychiatric **hospitals**;
- **Residential treatment facilities**;
- **Psychiatric physicians**;
- Psychologists;
- Social workers;
- Psychiatric nurses;
- Addictionologists;
- Substance abuse facility licensed by the department of mental health;
- Level III community-based detoxification; acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health;

- Mental health or substance abuse clinic licensed by the department of public health;
- A public community mental health center;
- Professional office or home-based services;
- Licensed independent clinical social worker;
- Licensed mental health counselor;
- Licensed nurse mental health clinical specialist; or
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services.

Mental Disorder *(GR-9N 34-065 04 MA)*

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist, a psychiatric social worker, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

Any one of the following conditions is a **mental disorder** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.
- Paranoia and other psychotic disorders.
- Delirium and dementia.
- Affective disorders.
- Eating disorders.
- Post traumatic stress disorders.
- Substance Abuse.
- All other mental disorders not otherwise identified and which are described in the most recent edition of the diagnostic and statistical Manual of Mental Disorders (DSM).

Also included is any other mental condition which requires **Medically Necessary** treatment.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Mental Disorders and Substance Abuse *(GR-9N S-11-062 01 MA)*		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Other than Room and Board	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Physician Services	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**

Inpatient Residential Treatment Facility Expenses	90% per admission after Calendar Year **deductible**	70% per admission after Calendar Year **deductible**
Outpatient Services	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	80% per visit after the Calendar Year **deductible**

Prescription Drug *(GR-9N 34-080-01 MA)*
A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- Drugs and medicines prescribed for the treatment of cancer or HIV/AIDS even if the off-label use of the drug has not been approved by the FDA for that indication. However, such drug for the treatment of such indication is in one of the standard reference compendia or in medical literature. The term "standard reference compendia" means the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information. The term "medical literature" means published scientific studies appearing in any peer-reviewed national professional journal.

Thirty-One Day Continuation *(GR-9N 31-015-01 MA)*
Coverage under this plan which terminates in accordance with the prior terms of this section will be continued for 31 more days, subject to the following.

- Termination is not due to discontinuance of the Group Contract, or failure to make any required contributions.
- This plan's benefits will be reduced by any other benefits of like kind for which the person becomes eligible.
- If this plan provides a medical expense benefits conversion privilege the following must be submitted to **Aetna** within the 31 day period of continuation:
  - Application for the personal policy; and
  - The premium.

This applies unless the person elects any other available continuation.

Continuation of Coverage for Your Former Spouse
If your health expense benefit coverage for your dependent spouse would terminate because of divorce or of separate support, you may continue any such coverage in force by continuing premium payments.

Coverage may be continued if the valid decree of dissolution of marriage states that you do not have to provide medical or dental coverage for your former spouse.

Coverage will be continued beyond the first to occur of:

- The date you are no longer covered under this Plan.
- The date dependent coverage is discontinued under this Plan for your Eligible Class.
- The end of the period for which required contributions have been made.
- The end of any period set forth in the valid decree of dissolution of marriage during which you are required to provide medical or dental coverage for your former spouse.
- The date you or your former spouse remarries. In the event of remarriage of the group plan member, the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family plan or issuance of an individual plan.

Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to the divorced or separated spouse at their last known address together with notice of the right to reinstate coverage retroactively to the date of cancellation.

Continuation of Coverage: Employment Ceases

If your employment terminates due to involuntary lay-off, you may continue Health Expense Coverage (except Dental Expense Coverage) for you and your dependents for 39 weeks. You must request that your coverage continue within 31 days after it would cease due to involuntary lay-off.

Coverage will cease before the end of the 39 weeks on the first to occur of:

- The date you are eligible for coverage under another group plan.
- The date you fail to make any contribution needed.
- The date Health Expense Coverage discontinues for employees of your former employer.
- The end of a period equal to the length of time you were last insured.

Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

Continuation of Coverage: Plant Closing

If your employment terminated due to a plant closing or partial closing, you may continue Health Expense Coverage, except Dental Expense Coverage for you and your dependents for 90 days. You must request that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Coverage will cease before the end of the 90 days on the first of:

- The date you are eligible for coverage under another group plan.
- The date you fail to make any contribution needed.

Coverage for a dependent will cease earlier when the person:

- Ceases to be a defined dependent.
- Becomes eligible for other coverage under the Group Policy.

The following terms are defined by Massachusetts law:

- Plant closing.
- Partial closing.

Continuation of Coverage for Your Dependents After Your Death

If you die while covered under any part of this plan, any Health Expense Coverage then in force for your dependents will be continued if:

- Your coverage is not then being continued after your employment has stopped due to involuntary lay-off.
- Such coverage is requested within 31 days after your death.
- Premium payments are made for the coverage.

Your spouse's coverage will cease when your spouse remarries. Any dependent's coverage, including your spouse's, will end when any one of the following happens:

- The end of the 39 week period right after the date the dependent's coverage would otherwise cease.
- The end of a period equal to the length of time you were last covered.
- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for coverage under this plan or another group plan.
- Dependent coverage ceases under this plan.
- Any required contributions cease.

Continuation of Coverage for Your Child

The terms of this Continuation of Coverage apply only to your dependent child:

- who attains the limiting age for eligibility; and
- whose coverage under this Plan would otherwise terminate; and
- who is engaged in an ongoing treatment under this Plan, in accordance with a written treatment plan, for a mental, behavioral, or emotional disorder.

Such child's health expenses coverage, except dental expense coverage, may be continued, if:

- written request for such continuation is made within 31 days of the date coverage terminates; and
- that such request includes the following:
  - an agreement to pay up to 100% of the cost to the plan; and
  - evidence, satisfactory to **Aetna,** of the existence of such a mental, behavioral, or emotional disorder.

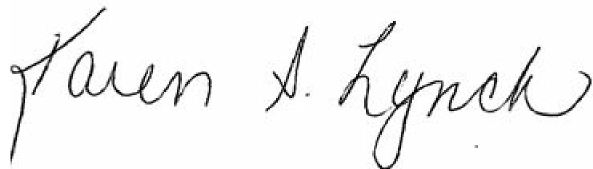
Premium payments must be made.

Coverage will cease on the first to occur of:

- the end of a 36 month period that starts on the date coverage would otherwise terminate (but not before the date a course of treatment for a non-biological mental disorder for children or adolescents under the age of 19, as specified in the treatment plan, is completed); or
- the date the child fails to provide the required proof that the course of treatment is still ongoing; or
- the date the child is eligible for similar benefits under any group plan; or
- the date the child becomes eligible for other coverage under the Group Policy; or
- the date the child fails to make any required contributions; or
- the date health expense coverage under this Plan discontinues for employees of your employer.

Aetna will have the right to require proof of the continuation of the course of treatment. **Aetna** also has the right to examine your child as often as needed while the course of treatment continues at its own expense. An exam will not be required more often than once each year.

If any coverage being continued ceases, the child may apply for a personal policy in accordance with the Conversion Privilege.



Karen S. Lynch
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Massachusetts Medical ET
Issue Date: October 1, 2020